

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$5,141.20 for date of service 01/05/01.
- b. The request was received on 01/03/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution dated 12/29/01
 - b. HCFA 1450
 - c. TWCC 62 forms
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60
 - b. HCFA(s)
 - c. TWCC 62 forms
 - d. Review of billed charges dated 02/22/01
 - e. Medical Records
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. The Commission case file does not contain a Notice of Medical Dispute signed by the carrier representative. The TWCC MDUL-1 form states, "RESPONSE RECEIVED DATE 01/18/02 Response code – T – TIMELY." The carrier response which was received on 01/18/02 will be considered timely.
4. This Commission case file does not contain a Notice of Medical Dispute.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 12/29/01 that, "...position is that this facility correctly and appropriately billed for the surgical procedure performed

on....Each and every item and service necessary for this surgical procedure including pre-operative laboratory studies and post-operative care were documented thoroughly....All of...statements are not sufficiently explanatory to enable...to fully respond, thereby denying...of its due process rights guaranteed under both the Texas Constitution and the United States Constitution.”

2. Respondent: Although the carrier did not submit a specific response to the request for the medical dispute, they did include a review letter dated 02/22/01 in response the provider’s billed charges. The letter states, “Charges for the facility in which the provider elected to have procedures or surgery performed on an outpatient basis are paid at a fair and reasonable amount pursuant to the criteria set forth in Section 413.011(b) of the Texas Workers’ Compensation Act. In light of the reduced expenses incurred in an outpatient setting, it is unreasonable to pay more for an outpatient procedure or surgery than an inpatient surgery. The established per diem rate for an inpatient surgical day is set at \$1118.00. The per diem rate for a non-surgical inpatient medical stay is set at \$870.00.

Using these two rates as anchor points, the following schedule of fair and reasonable payment that comport with the reimbursement standards established by section 413.011(b)...for facility charges for outpatient procedures or surgery has been established based on time listed in the operating Room [sic]:

Outpatient procedures or surgeries of 29 minutes or less in the Operating Room	\$870.00
Outpatient procedures or surgeries of 30-60 minutes in the Operating Room	\$900.00
Outpatient procedures or surgeries of 61 to 90 minutes in the Operating Room	\$1,000.00
Outpatient procedures or surgeries of more than 91 minutes in the Operating Room	\$1,100.00

Based on the above schedule, it is recommended that the outpatient procedure or surgery performed on...at the listed 61-90 minutes of Operating Room time on 1-05-01 at...be paid at \$1000.00. Per bill review. Dr’s procedure time is listed at 90 minutes.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 01/05/01.
2. The provider billed \$6,141.02 for services rendered for date of service 01/05/01.
3. The carrier reimbursed the provider \$1,000.00 for date of service 01/05/01.
4. The amount in dispute for date of service 01/05/01 is \$5,141.02.

5. The provider unbundled the treatment services. According to Rule 133.1 (3) (E) (16), unbundling is “Submitting bills in a fragmented way, using separate billing codes for multiple treatments or services when there is a single billing code that includes all of the treatments and services that were billed separately, or fragmenting one treatment or service into its component parts and coding each component part as if it were a separate treatment or service.”
6. The carrier denial codes include “N – Not Documented” and “M – Reduced to fair and reasonable.” Since ASC billing is for facility fees only, the “M” denial code addressed in this document will be considered the denial code of the billed charges. This denial code was rendered to the provider prior to the submission of this dispute being filed. Therefore, the Medical Review Division’s decision is rendered based on denial codes submitted to the provider prior to the date of this dispute being filed.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a) (4) states ASCs, “shall be reimbursed at a fair and reasonable rate...”

Section 413.011 (d) of the Texas Labor Code states, “Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.”

The provider submitted additional reimbursement data (EOBs from various carriers) in an attempt to demonstrate payments of fair and reasonable documentation for treatment of an injured individual of an equivalent standard of living in their geographical area. The documentation submitted by the provider is insufficient to meet the criteria of Rule 133.307 (g) (3) (d) demonstrating fair and reasonable reimbursement. As the Requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable.

The Carrier submitted reimbursement data to document what they consider fair and reasonable reimbursement and to comply with Commission Rule 133.304 (i) (1-4). The carrier compares the amount of reimbursement the provider received with the amount of reimbursement the Medical Fee Guidelines allow a hospital for inpatient surgery. The carrier submitted their methodology and though, the entire methodology may not necessarily be concurred in by the Medical Review Division, the requirements of the referenced Rule have been met.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine based on the parties’ submission of information, which party has provided the more persuasive evidence. Both parties to the dispute have submitted documentation in support of

their position. However, the carrier's documentation is more persuasive and meets the requirement of Sec. 413.011(d) of the Texas Labor Code, "to achieve effective medical cost control." Therefore, no additional reimbursement is recommended.

The above Findings and Decision are hereby issued this 17th day of May, 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.